Centers for Medicare and Medicaid Services
Special Terms and Conditions

NUMBER: 11-W-0000-5/4-01

TITLE: The Kentucky Health Care Partnership

AWARDEE: Commonwealth of Kentucky

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I. PREFACE

The following are special terms and conditions for the award of the Kentucky Partnership Plan demonstration amendment. The terms and conditions have been arranged into three broad subject areas: General Conditions for Approval; Legislation; and Program Design/Operational Plan.

In addition, specific requirements are attached, entitled: Requirements for Federal Financial Participation/Cost Control/Fiscal Administration (Attachment A); General Administrative Requirements (Attachment B); General Reporting Requirements (Attachment C); Monitoring of Budget Neutrality (Attachment D); Access Standards (Attachment E); Outline for Operational Protocol (Attachment F); and Encounter Data Requirements (Attachment G).

II. GENERAL CONDITIONS

1. All special terms and conditions prefaced with an asterisk (*) contain requirements that must be approved by the Centers for Medicare & Medicaid Services (CMS) prior to marketing, enrollment, or implementation. No Federal financial participation (FFP) will be provided for marketing, enrollment or implementation until CMS has approved these requirements. FFP will be available for project development and implementation, and for compliance with terms and conditions, the readiness review, etc. Unless otherwise specified where the State is required to obtain CMS approval of a submission, CMS will make every effort to respond to the submission in writing within 30 days of receipt of the submission. CMS and the State will make every effort to ensure that each submission is approved within 60 days from the date of CMS's receipt of the original submission.

*2. Within 60 days of award, the State will submit a pre-implementation workplan for approval by the CMS project officer. The workplan will specify timeframes for major tasks and related subtasks for managed care expansion.

*3. The State shall prepare one protocol document that represents and provides a single source for the policy and operating procedures applicable to this demonstration which have been agreed to by the State and CMS during the course of the waiver negotiation and approval process. The protocol must be submitted to the CMS project officer no later than 70 days prior to the implementation date of the program (implementation defined as the first date when beneficiaries select a health plan). CMS will respond within 30 days of receipt of the protocol regarding any issues or areas it believes require clarification. CMS and the State will make every effort to ensure that the protocol is approved within 60 days from the date of its original submission. During the demonstration, subsequent changes to the protocol which are the result of major changes in policy or operating procedures should be submitted no later than 60 days prior to the date of implementation of the change(s) for approval by CMS. The Special Terms and Conditions and Attachments include requirements that should be included in the protocol. Attachment F is an outline of areas that should be included in the protocol. Where not specified in the protocol, the State's original demonstration proposal, as modified or clarified in written responses to CMS questions, shall govern.

4. All net savings derived from the implementation of this demonstration shall be maintained in a Medicaid Trust Fund established by the Commonwealth of Kentucky to fund the expansion of the delivery of health care services to indigents. The application of the net savings for the use of expanding health care services to Kentucky's indigent population is a material term of the conditions of approval of the demonstration, and non-compliance with this term shall result in the revocation of this demonstration.

5. a. The State will submit a phase-out plan of the demonstration to CMS 6 months prior to initiating normal phase-out activities and, if desired by the State, an extension

plan on a timely basis to prevent disenrollment of members if the demonstration is extended by CMS. Nothing herein shall be construed as preventing the State from submitting a phase-out plan with an implementation deadline shorter than 6 months when such action is necessitated by emergent circumstances. The phase-out plan is subject to CMS review and approval.

b. During the last 6 months of the demonstration, eligibility determination of individuals who would not be eligible for Medicaid under the current State plan will not be permitted unless the demonstration is extended by CMS.

6. CMS may suspend or terminate any project in whole or in part at any time before the date of expiration, whenever it determines that the awardee has materially failed to comply with the terms of the project. CMS will promptly notify the awardee in writing of the determination and the reasons for the suspension or termination, together with the effective date. The State waives none of its rights to challenge CMS's finding that the State materially failed to comply. CMS reserves the right to withdraw waivers or expenditure authority at any time if it determines that continuing the waivers or expenditure authority would no longer be in the public interest. If a waiver or expenditure authority is withdrawn, CMS will be liable for only normal close-out costs.

7. The State will comply with:

- Requirements for Federal Financial Participation/Cost Control/Fiscal Administration (Attachment A)
- General Administrative Requirements (Attachment B)
- General Reporting Requirements (Attachment C)
- Monitoring of Budget Neutrality (Attachment D)
- Access Standards (Attachment E)
- Outline for Operational Protocol (Attachment F)
- Recommended Minimum Data Set (Attachment G)

III. LEGISLATION

1. a. All requirements of the Medicaid program expressed in law not expressly waived or identified as not applicable in the award letter of which these terms and conditions are part, shall apply to the Partnership. To the extent the enforcement of such laws through regulations and official policy statements issued by a Bureau director and/or Associate Regional Administrator or higher would have affected State spending in the absence of the demonstration in ways not explicitly anticipated in this agreement, CMS shall incorporate such effects into a modified budget limit for the Partnership. The modified budget limit would be effective upon enforcement of the law, regulation, or policy statement. CMS will have two years after the demonstration award date to notify the State that it intends to take action. The growth rates for the budget neutrality baseline, as described in Attachment D, are not subject to this special term and condition. If the law, regulation, or policy statement cannot be linked specifically with program components that are or are not affected by the Partnership (e.g., all disallowances involving provider taxes or donations), and if CMS and the State working in good faith to ensure State flexibility in deciding where the appropriate modifications should occur, do not agree within 90 days to establish an alternative methodology for revising the without waiver baseline, the effect of enforcement on the State's budget limit shall be proportional to the size of the Partnership in comparison to its entire Medicaid program (as measured in aggregate medical assistance payments).

   b. The State shall, within the timeframe specified in law, come into compliance with any changes in Federal law affecting the Medicaid program that occur after October 6, 1995. To the extent that a change in Federal law, which does not exempt State section 1115 demonstrations, would affect State Medicaid spending in the absence of the waiver, CMS shall incorporate such changes into a modified budget limit for the Partnership. The modified budget limit would be effective upon implementation of the change in Federal law, as specified in law. If the new law cannot be linked specifically with program components that are or are not affected by the Partnership (e.g., laws affecting sources of Medicaid funding), the State shall submit its methodology to CMS for complying with the change in law. If the methodology is consistent with Federal law and in accordance with Federal projections of the budgetary effects of the new law in Kentucky, CMS would approve the methodology. Should CMS and the State, working in good faith to ensure State flexibility, fail to develop within 90 days a methodology to revise the without waiver baseline that is consistent with Federal law and in accordance with Federal budgetary projections, a reduction in Federal payments shall be made according to the method applied in non-waiver States.

   c. The State may submit to CMS an amendment to the program to request exemption from changes in law occurring after October 6, 1995. The cost to the Federal government of such an amendment must be offset to ensure that total projected expenditures under the

modified Partnership demonstration do not exceed projected expenditures in the absence of the Partnership (assuming full compliance with the change in law).

IV. PROGRAM DESIGN/OPERATIONAL PLAN

A. ELIGIBILITY REVIEW

1. The State will continue to maintain a Medicaid Eligibility Quality Control (MEQC) program for all Medicaid eligibles. This data combined with other information shall be used to implement control mechanisms. Control mechanisms to be implemented shall be included in the protocol.

B. CAPITATION RATES

1. The State will submit to CMS for review and approval all capitation rates, and the fee-for-service upper payment limits from which they are derived, for the Partnership plans throughout the demonstration. Also, the State will submit the methodology for determining the fee-for-service upper payment limits for services.

C. PARTNERSHIP PLAN CONTRACTING

1. a. The State will provide CMS with 30 days to review and approve the executed contract prior to its use. No FFP will be available for contracts using a contract which has not been approved by CMS in advance of the effective dates of the contracts.

b. The State will notify the CMS project officer of significant changes to the Partnership Plan and the State shall define within its protocol contingency plans for assuring continued access to care for enrollees in the case of a Partnership contract termination and/or insolvency.

c. CMS reserves the right to review and approve individual subcontracts with Partnership plans in accordance with the same requirements as those imposed by these Special Terms and Conditions on Partnership plans. Copies of subcontracts or individual provider agreements with Partnership plans shall be provided to CMS upon request.

d. Where applicable, the State shall establish a process by which it receives, reviews, and approves all marketing materials prior to their use by Partnership plans.

e. In the protocol, the State shall describe how homeless populations will access health care services under the demonstration. The protocol will include a description of how providers of care to this population will be incorporated in the managed care model and reimbursed for their services to this population.

4. a. The State must provide the methodology it will use to determine whether each Partnership plan has an adequate provider network in relation to the geographic location

of Medicaid beneficiaries. The State should consider using a computer mapping program showing average distance between eligibles and primary care/specialty physicians and other providers.

b. If CMS decides to run a computer mapping program, the State shall make available addresses of demonstration eligibles and providers.

c. The State must provide the methodology it is using to determine whether each region in the State (as defined by the State) has sufficient provider capacity to justify mandatory managed care enrollment. This should consider both the pre- and post-implementation percentage of provider caseloads open to Medicaid clients in relation to the geographic location of Medicaid beneficiaries.

d. The State must provide the CMS Regional Office (RO) with an annually updated listing of all providers (primary and specialty) participating in the demonstration.

e. In the protocol, the State will provide assurances to CMS that the fee-for-service system will be maintained in areas where Partnership capacity does not meet the needs of the Medicaid beneficiaries. Also in the protocol, the State will assure that plan services are reimbursed for beneficiaries from the effective date of eligibility until their services are reimbursed by a Partnership.

*5. The State must meet the usual Medicaid disclosure requirements at 42 CFR 455, Subpart B, for contracting with the Partnership prior to the start date of the demonstration. Such requirements include disclosure of ownership and completion of the standard CMS disclosure form.

D. FAMILY PLANNING

*1. In the protocol, the State shall submit a written plan that describes how family planning services will be made available to Partnership plan enrollees, if the plans choose not to contract with Title X programs. The plan must delineate how the confidentiality of enrollees (particularly adolescents) who receive family planning services through such plans will be maintained.

E. FEDERALLY QUALIFIED HEALTH CENTERS (FQHCs)

*1. a. The State shall as a general rule require the Partnership to contract with FQHCs in their service area. However, if the State can demonstrate to CMS that the plans have adequate capacity and will provide an appropriate range of services for vulnerable populations without contracting with an FQHC in its service area, the Partnership can be relieved of this requirement.

b. For any Partnership that requests an exemption from the requirement that it contract with FQHCs, the State shall submit to CMS a report with the following

information at least 60 days prior to submission of the final managed care contract for CMS approval:

1) The FQHCs in the Partnership's service area, and a description of the demonstration populations served and the services provided by the FQHCs prior to the demonstration.

2) An analysis that the Partnership has sufficient provider capacity to serve the demonstration populations currently receiving services at the FQHC. The analysis should include, but not be limited to, a listing of providers signed with the Partnership, capacity of each provider to take on additional Medicaid patients, geographic location of providers and description of accessibility for Medicaid patients to these providers. The Partnership must inform the State if any of this information changes over the course of the demonstration.

3) An analysis that the Partnership will provide a comparable level of Medicaid services as the FQHC (as covered in the approved State Medicaid plan), including covered outreach, social support services, and the availability of culturally sensitive services, such as translators and training for medical and administrative staff. The analysis should describe the proximity of providers, and range of services as it relates to FQHC patients, to the extent these services are currently available through FQHCs in the service area.

c. The Partnership will pay the FQHC(s) on either a capitated (risk) basis (with appropriate adjustments for risk factors) or on a cost-related basis. A description of the payment methodology shall be provided by the State. If during the demonstration, the Partnership changes its payment methodology to an FQHC, the changes must be submitted by the State to CMS for review and approval.

F. ENCOUNTER DATA REQUIREMENTS

1. a. The State shall define a minimum data set (which at least includes inpatient and physician services) and require all providers to submit these data. The recommended minimum data set is attached. The State must perform periodic reviews, including validation studies, in order to ensure compliance, and shall have provisions in its contract with the managed care organizations to provide the data and be authorized to impose financial penalties if accurate data are not submitted in a timely fashion. Within the protocol, the State shall submit the proposed minimum data set and a workplan showing how collection of plan encounter data will be implemented and monitored, and how the State will use the encounter data to monitor implementation of the project and feed findings directly into program change on a timely basis. If the State fails to provide reasonably accurate and complete encounter data for any Partnership plan, it will be

responsible for providing to the designated CMS evaluator data abstracted from medical records comparable to the data which would be available from encounter reporting requirements.

b. The State, in collaboration with the Partnership plans and other appropriate parties, will develop a detailed plan, submitted to CMS within the protocol, for using encounter data to pursue health care quality improvement. At a minimum, the plan shall include: how the baseline for comparison will be developed; what indicators of quality will be used to determine if the desired outcomes are achieved; where the data will be stored; how data will be validated and how monitoring will occur; and what penalties will be incurred if information is not provided. Prior to implementation in each region, the State shall submit a report demonstrating that the Partnership plans have the capability to collect valid and reliable encounter data.

c. At a minimum, the State's plan for using encounter data to pursue health care quality improvement must focus on the following priority areas:

- childhood immunizations;
- prenatal care and birth outcomes;
- pediatric asthma; and
- two additional clinical conditions to be determined by the State based upon the population(s) served.

d. The State shall conduct annual validity studies to determine the completeness and accuracy of the encounter data collected. The State shall submit a plan for CMS approval within the protocol describing how it will validate the completeness and accuracy of the encounter data.

G. QUALITY ASSURANCE/QUALITY IMPROVEMENT REQUIREMENTS & MONITORING PLAN

*1. a. In the protocol, the State shall provide its overall quality assurance/quality improvement criteria and monitoring plan for the Partnership. The State shall develop quality audits to be conducted by the State and an external review agency to monitor the performance of the plans under the Partnership. The State will contract with the external review agency prior to the implementation of each Partnership, with the stipulation that the contract review occur within the first year. At a minimum, the State shall monitor the financial performance and quality assurance activities of each plan. In the protocol, the State shall provide detailed criteria for monitoring the financial performance and quality assurance (including compliance with access standards) of each plan. Upon request from CMS, the State shall submit to both the CMS central and regional offices copies of all financial audits of participating health care Partnerships and quality assessment reviews of these plans.

b. The State shall describe its procedures for monitoring the Partnership's quality assurance (QA) system. Prior to implementation, the State shall conduct a review to

determine whether the plan has an appropriate QA system. Six months after implementation, the State shall conduct a review of the implemented program and submit a report to CMS.

2. a. Within 12 months of implementation, the State shall conduct a survey of the Partnership plan. The survey, which shall be described in the protocol, will measure satisfaction and include: measures of out-of-plan use, to include use of emergency rooms; average waiting time for appointments, including physician office visits; average time and distance to reach providers; access to special providers; the number and causes of disenrollments; and coordination with other health programs. Results of the survey must be provided to CMS by the 15th month of project implementation. Thereafter, the State shall conduct beneficiary surveys during each year of the demonstration as part of its quality improvement and performance monitoring process. Such survey shall be designed to produce statistically valid results.

b. The State shall establish a quality improvement process for bringing health care partnership plans which score below the State's benchmarks for specific and overall beneficiary satisfaction measures up to an acceptable level. The State will specify the benchmarks in the protocol.

3. a. Kentucky shall collect and review quarterly reports on grievances received by each Partnership plan which describe the resolution of each formal grievance. Quarterly reports must also include an analysis of logs of informal complaints (which may be verbally reported to customer service personnel) as well as descriptions of how formal (written) grievances and appeals were handled. The State will work with medical representatives and consumer advocates throughout the appeals process.

b. Beneficiaries shall be allowed to change primary care providers within the Partnership at any time for good cause subject to the approval of a designated State agency. The State will describe the mechanisms for determining good cause in the protocol.

c. The State shall submit quarterly reports summarizing the disposition of requests for disenrollment for good cause. For each request that was denied, the State shall submit a brief description of the rationale for denial.

4. Guidelines for State Monitoring of the Partnerships

a. The State will require, by contract, that the Partnerships meet certain State-specified standards for Internal Quality Assurance Programs (QAPs) as required in 42 CFR 434.

b. The State will monitor, on a periodic or continuous basis (but no less often than every 12 months), the Partnerships' adherence to these standards, through the following mechanisms: review of each plan's written QAP; review of numerical data and/or

narrative reports describing clinical and related information on health services and outcomes; and on-site monitoring of the implementation of the QAP standards.

5. Guidelines for Partnerships' Monitoring of Providers

The Partnerships will require, by contract, that providers meet specified standards as required by the State contract. The Partnerships will monitor, on a periodic or continuous basis, providers' adherence to these standards, and recipient access to care.

6. The State will establish and maintain an oversight committee, consisting of beneficiaries, consumer advocates, and public health officials to offer input on the status of the Partnerships during the demonstration period.

7. The Partnerships will satisfy access and solvency requirements in section 1903(m)(1)(A)(i)(ii) of the Act, and shall meet requirements in section 1902(w).

H. MANAGEMENT INFORMATION SYSTEMS

*1. The State will develop a Detailed Implementation Schedule (DIS) addressing the State's approach to achieving changes, modifications and enhancements to its Medicaid Management Information System (MMIS), Eligibility System (ACCESS) and other systems capability to ensure the State's readiness to:

a. Collect, process, and maintain recipient eligibility information necessary to support recipient enrollment;

b. Collect, process, and maintain health plan information necessary to support plan enrollment;

c. Process and pay capitation fees and other required compensation to participating plans;

d. Collect, validate and use encounter data from participating plans.

The DIS should include the components set forth in State Medicaid Manual (SMM) section 11237.

*2. Prior to enrollment of beneficiaries, the State must submit evidence to the CMS Regional Office that a management information system is in place which meets the minimum standards of performance or the functional equivalent required of the State's current management information system.

ATTACHMENT A

Requirements for Federal Financial Participation/Cost Control/Fiscal Administration

1. a. The State will report net expenditures in the same manner as is done under the current Medicaid program. The State shall provide quarterly expenditure reports using the form CMS-64 to separately report expenditures for those receiving services under the regular Medicaid program and those participating in the Partnership under section 1115 authority. CMS will provide Federal Financial Participation (FFP) only for allowable Partnership expenditures that do not exceed the pre-defined limits as specified in Attachment D.

   b. Kentucky will report Partnership expenditures through the Medicaid Budget Expenditure System (MBES), following routine CMS-64 reporting instructions outlined in Section 2500 of the State Medicaid Manual. In this regard, the Partnership expenditures will be differentiated from other Medicaid expenditures by identifying on forms CMS-64.9 and/or 64.9p the demonstration project number assigned by CMS. Because expenditures are reported on the CMS-64 by date of payment, Kentucky must also submit along with each CMS-64 quarterly report a supplemental schedule that details services and reported waiver expenditures according to the demonstration year in which the services were provided. The procedure related to under this reporting process must be approved by CMS as part of the protocol referenced in II.3 of these Special Terms and Conditions.

   c. All claims for Partnership services provided during the demonstration period (including any cost settlements) must be made within 2 years after the calendar quarter in which the State made the expenditures. During the period following the conclusion or termination of the demonstration, the State must continue to separately identify Partnership demonstration expenditures using the procedures addressed above.

   d. In addition to form CMS-64, the State shall provide to CMS, on a quarterly basis, the number of eligible member/months for each enrollee group listed in Attachment D. This information should be provided to CMS 30 days after the end of each quarter.

2. The standard Medicaid funding process will be used during the demonstration. The State must estimate matchable Kentucky Medicaid and Partnership expenditures on the quarterly form CMS-37. The State must provide supplemental schedules that clearly distinguish between demonstration expenditure estimates (by major component) and non- demonstration Medicaid expenditure estimates. CMS will make Federal funds available each quarter based upon the State's estimates, as approved by CMS. Within 30 days after the end of each quarter, the State must submit the form CMS-64 quarterly Medicaid expenditure report, showing Medicaid expenditures made in the quarter just ended. CMS will reconcile expenditures reported on the Form CMS-64 with Federal funding previously made available

to the State for that quarter, and include the reconciling adjustment in a separate grant award to the State.

3. CMS will provide FFP at the applicable Federal matching rate for the following, subject to the limits described in Attachment D:

   a. Administrative costs associated with the administration of the Partnership.

   b. Net expenditures and prior period adjustments of the Medicaid program, which are paid in accordance with the approved State plan. CMS will provide FFP for medical assistance payments with dates of service prior to and during the operation of the section 1115 waiver.

   c. State/local monies certified by the State and used as matching funds for the Partnership's purposes and further certified that such funds will not be used as matching funds for any other Federal grant or contract, except as permitted by Federal law.

4. Guidelines for Financial Monitoring of Participating Providers

   a. The State shall provide to CMS, upon request, copies of all financial statements filed by insurers and HMOs with the Kentucky Department of Insurance.

   b. The State shall provide to CMS, upon request, copies of any Department of Insurance documents related to their monitoring of the financial stability of insurers and HMOs.

   c. The State shall provide to CMS, upon request, copies of all audits conducted by the State under the Federal Single Audit Act.

ATTACHMENT B

General Administrative Requirements

1. Kentucky will request modifications to the demonstration by submitting revisions to the protocol (see Special Term and Condition section II.3) for CMS approval. These modifications will include significant changes in policy and procedures.

2. Substantive changes to the demonstration design will require submission of a formal amendment to the proposal and advance CMS approval. The State will work with CMS in amending the demonstration application in the later stages of the demonstration program.

3. By April 1 of each year, the State will submit Form CMS-416, EPSDT program reports for the previous Federal fiscal year. These reports will follow the format specified in section 2700.4 of the State Medicaid Manual, with data for each line item arrayed by age group and basis of eligibility. Copies should be submitted simultaneously to CMS's Atlanta Regional Office and to the CMS Central Office address contained in section 2700.4 of the State Medicaid Manual. All data reported must be supported by documentation consistent with the general requirements of these terms and conditions. Included in the report, the State shall describe how EPSDT compliance will be improved to meet the State's goal.

4. All contracts and subcontracts for services related to the Partnership must provide that the State agency and the U.S. Department of Health and Human Services may: (1) evaluate through inspection or other means the quality, appropriateness, and timeliness of services performed; and (2) inspect and audit any financial records of such contractor/subcontractors. This includes contracts with the Partnerships and Third Party Administrators (TPAs).

ATTACHMENT C

General Reporting Requirements

1. Through the first 6 months after implementation, the State will report on its progress in a series of monthly conference calls with the CMS project officer, and will develop a detailed agenda prior to each call. Subsequently, the State will submit quarterly progress reports (including grievances), which are due 60 days after the end of each quarter.

   The reports should include a brief narrative of events occurring during the quarter that will affect access to health care, enrollment, quality of care (including statistics on grievances), the Partnership Plan's financial viability, or other key operational areas. The report should include a separate discussion of State efforts related to the collection and verification of encounter data and provide summary utilization statistics (beginning in the third quarter). The report should also include proposals for addressing any significant problem areas.

2. The State will submit a draft annual report, documenting accomplishments, project status, quantitative and case study findings, and policy and administrative difficulties no later than 120 days after the end of its operational year. Within 30 days of receipt of comments from CMS, a final annual report will be submitted.

3. At the end of the demonstration, a draft final report should be submitted to the CMS project officer for comments. CMS's comments should be taken into consideration by the awardee for incorporation into the final report. The awardee should use the CMS Author's Guidelines: Grants and Contracts Final Reports in the preparation of the final report. The final report is due no later than 90 days after the termination of the project.

ATTACHMENT D

Monitoring Budget Neutrality for the Kentucky Health Care Partnership (KHCP) Demonstration

The following describes the method by which budget neutrality will be assured under the Kentucky KHCP Demonstration. Kentucky will be subject to a limit on the amount of Federal title XIX funding that the State may receive on selected Medicaid expenditures during the waiver period. This limit will be determined using a per capita cost method. In this way, Kentucky will be at risk for the per capita cost (as determined by the method described below) for Medicaid eligibles, but not at risk for the number of eligibles. By providing FFP for all current eligibles, CMS will not place Kentucky at risk for changing economic conditions. However, by placing Kentucky at risk for the per capita costs of current eligibles, CMS assures that the demonstration expenditures do not exceed the levels that would have been realized had there been no demonstration.

For the purpose of calculating the overall expenditure limit for the demonstration, separate budget estimates will be calculated for each year, on a waiver year (WY) basis. The annual estimates will then be added together to obtain an expenditure estimate for the entire waiver period. The Federal share of this estimate will represent the maximum amount of FFP that the State may receive during the 8-year waiver period for the types of Medicaid expenditures described below. For each FFY, the Federal share will be calculated using the FMAP rate for that year.

Each yearly budget estimate will be the product of the projected per member/per month (PMPM) cost for Medicaid recipients participating in the demonstration, times the actual number of eligible member/months as reported to CMS by the State under Attachment A.

Projecting PMPM Cost

Projected PMPM cost for each category will be determined by using a pre-determined set of trend factors to convert base year PMPM costs into current year projected PMPM costs for each year of the demonstration.

Base year

The State shall submit to CMS a base year PMPM cost, subject to the approval of the Project Officer. The base year PMPM cost must conform to the following requirements:

- The base year PMPM cost must reflect expenditures related to services performed during State fiscal year (SFY) 1995 (i.e., expenditures should be totaled on a date of services basis) for all recipients who would have participated in the demonstration, had it been in place at the time.

- They must include expenditures for all services for which prepaid plans will be responsible under the demonstration; i.e., all acute care services with the exception of behavioral health or mental heath services.

- The recipient totals used must include all recipient member/months that would have participated in the Partnership demonstration had that program been in place in SFY 95.

By December 31, 1995, the State shall submit to the Project Officer estimates of SFY 95 PMPM cost, based on claims submitted to that point and an estimated completion factor. By July 31, 1996, the State shall submit to the Project Officer the final PMPM cost figure, subject to Project Officer approval. The latter PMPM cost will be the one used in calculating the actual FFP limit, and may include Medicaid claims submitted to the State through June 30, 1996, for services rendered during SFY 95.

Under Kentucky statute, certain physician rates were reduced below the levels that they would have attained without legislative action. The rate reduction took effect on December 13, 1994. Physician rates are anticipated to return to their normal level after April 15, 1996. The following rules will govern how the effects of these rate changes will be incorporated into the expenditure limits:

- If the rate reduction expires on April 15, 1996, base year PMPM expenditures will be adjusted upward to remove the effect of the rate reduction on total (and PMPM) expenditures in SFY 95.

- If as a result of further legislative action the rate reduction is extended beyond April 15, 1996, the base year PMPM costs must be adjusted downward to reflect a full year's impact of the rate reductions.

- All adjustments to base year PMPM costs and the expenditure limit are subject to approval by both the State and the Project Officer.

Trend Rates

An annual trend rate not to exceed 6.6 percent for demonstration years 6 (FFY 2003), 7 (FFY 2004), and 8 (FFY 2005) will be used to project per member/per month (PMPM) costs throughout the demonstration period. The equivalent monthly growth rate, 0.5025 percent, will be used to project PMPM costs for the first year of the waiver, in the event that the first WY does not coincide with the State fiscal year.

Using the trend rates to produce non-Federal fiscal year PMPM cost estimates

In the event that the beginning of the demonstration does not coincide with the start of the State fiscal year, the monthly growth rate of 0.5025 percent will be used to convert the SFY 95 PMPM costs into first WY PMPM costs. The number of months of growth used will depend on the number of months between the midpoint of SFY 95 and the midpoint of the first waiver year.

For example, suppose the base year (SFY 95) PMPM cost was $287.91. Suppose further that the first year of the demonstration begins 5/1/96 and ends 4/30/97. This first demonstration year will be referred to as WY 97. Since the midpoint of WY 97 (11/1/96) is 22 months beyond the midpoint of SFY 95 (1/1/95), 22 months of growth must be applied to convert SFY 95 PMPM cost to WY 97 PMPM cost. Twenty-two months of growth at 0.5025 percent corresponds to a total growth factor of 11.66 percent. Applying the 11.66 percent growth factor to the base year PMPM cost of $287.91 gives a WY 97 PMPM cost of $321.48. If during WY 1997 the State were to report 6,346,800 enrollee/months, the resulting budget estimate for WY 97 is $321.48 X 6,346,800 = $2,040,369,264.

The following year (WY 98) and each subsequent year until the end of the demonstration, PMPM cost estimates would be calculated using an annual growth rate projected for the demonstration. In the above example, the PMPM cost estimate for WY 98 would be $321.48. X (1.062) = $341.41.

How the Limit Will Be Applied

The limit calculated above will apply to actual expenditures, as reported by the State under Attachment A, Special Term and Condition #1(c). If at the end of the demonstration period the budget neutrality provision has been exceeded, the excess Federal funds will be returned to CMS. No new limit is placed on the FFP that the State can claim for expenditures for recipients and program categories not listed. If the demonstration is terminated prior to the 8-year period, the budget neutrality test will be based on the time period through the termination date.

Expenditure Review

CMS shall enforce budget neutrality over the life of the demonstration, rather than on an annual basis. However, no later than six months after the end of each waiver year, the State will calculate annual expenditure targets for the completed year. The annual component targets will be summed to calculate a target annual spending limit. This amount should be compared with the actual claimed FFP for Medicaid. Using the schedule below as a guide, if the State exceeds these cumulative targets they shall submit a corrective action plan to CMS for approval. The State will subsequently implement the approved program.

- Year 1 target spending limit	+8 percent
- Years 1 to 2 combined target spending limit	+6 percent
- Years 1 to 3 combined target spending limit	+4 percent
- Years 1 to 4 combined target spending limit	+2 percent
- Years 1 to 5 combined target spending limit	+0 percent
- Years 1 to 6 combined target spending limit	+2 percent
- Years 1 to 7 combined target spending limit	+1 percent
- Years 1 to 8 combined target spending limit	+0 percent

ATTACHMENT E

Access Standards

Contractors shall provide available, accessible, and adequate numbers of institutional facilities, service locations, service sites, professional, allied and paramedical personnel for the provision of all covered services on an emergency basis, 24-hour-a-day, 7-day-a-week basis. The term "usual and customary" is defined as access that is equal to or greater than the currently existing practice in the fee-for-service system.

1. Primary Care Delivery Site

Distance/Time

No more than 30 miles or 30 minutes for all enrollees in urban areas and for enrollees in rural areas the norm shall be no more than 45 miles or 45 minutes from residence or place of employment.

Patient Load

The maximum Partnership patient/primary care physician ratio shall not exceed 1500:1 and shall be approved by the CMS project officer 30 days prior to implementation of the program. The State, subject to CMS approval, may approve exceptions to this standard in specified situations.

Appointment/Waiting Times

Usual and customary practice not to exceed 30 days from date of a patient's request for routine and preventive office visits and 48 hours for urgent care.

Documentation/Tracking requirements

- Documentation - The Partnerships must have a system in place to document appointment scheduling times. Kentucky must utilize statistically valid sampling methods for monitoring compliance with appointment/waiting time standards as part of the required beneficiary survey to ensure quality of care.

- Tracking - The Partnerships must have a system in place to document the exchange of client information with the primary care provider if a school-based health center, not serving as the primary care provider, provides health care.

2. Specialty Care and Emergency Care

Referral appointments to specialists, except for specialists providing mental health and substance abuse services, (e.g., specialty physician services, hospice care, home health care, and certain rehabilitation services, etc.) shall not exceed 30 days for routine care or 48 hours

for urgent care. All emergency care must be provided immediately, at the nearest facility available, regardless of contracts.

3. **Hospitals**

Transport time will be the usual and customary, not to exceed 30 minutes, except in rural areas where access time may be greater, and for mental health and physical rehabilitative services where access is not to exceed 60 minutes. If greater, the standard needs to be the community standard for accessing care, and exceptions must be justified and documented to Kentucky on the basis of community standards.

4. **General Dental Services**

(a) Transport time will be the usual and customary, not to exceed 1 hour, except in rural areas where community standards and documentation will apply.

(b) Appointment/Waiting Times: Usual and customary not to exceed 3 weeks for regular appointments and 48 hours for urgent care.

5. **General Optometry Services**

a) Transport time will be the usual and customary, not to exceed 1 hour, except in areas where community standards and documentation shall apply.

b) Appointment/Waiting Times: Usual and customary not to exceed 30 days for regular appointments and 48 hours for urgent care.

6. **Pharmacy Services**

Transport time will be the usual and customary, not to exceed 1 hour, except in areas where community access standards and documentation will apply.

7. **Lab and X-Ray Services**

a) Transport time will be the usual and customary, not to exceed 1 hour, except in areas where community access standards and documentation will apply.

b) Appointment/Waiting Times: Usual and customary not to exceed 30 days for regular appointments and 48 hours for urgent care.

8. **All other services not specified here shall meet the usual and customary standards for the community.**

ATTACHMENT F

Outline for Operational Protocol

Kentucky will be responsible for developing a detailed protocol describing The Partnership Plan. The protocol is a stand alone document that reflects the operating policies and administrative guidelines of the demonstration. The State shall assure and monitor compliance with the protocol. Areas that should be addressed in the document include:

1. organizational and structural configuration of the demonstration arrangements

2. organization of managed care networks, and procedures for determining adequate managed care provider capacity by region; as well as the process and criteria applied for provider selection

3. payment mechanism

4. benefit package

5. marketing and outreach strategy (i.e., State-initiated marketing and recipient education activities; oversight of plan-initiated marketing activities)

6. enrollment process

7. toll-free hotline for beneficiaries and providers

8. quality assurance and utilization review system, focusing particularly on internal quality assurance plan (QAP) requirements for the Partnership

9. administrative and management system, including State staffing capacity for both FFS and managed care

10. encounter data

11. federally qualified health centers/rural health centers

12. family planning services

13. financial reporting, including procedures for addressing insolvency issues

14. recipient grievance and appeal process, including requests to change PCPs for good cause

15. Partnership plan capacity for recordkeeping, staffing, and encounter data collection

16. mechanism for ensuring adequate access to EPSDT services

17. provider incentives for enhancing quality

18. a system for deterring, detecting, and resolving fraud and abuse cases

19. an oversight committee responsible for quality assurance and beneficiary access.

CMS review and approval of the protocol will be consistent with the waivers and expenditure authority granted and the proposal, as amended by the questions and answers submitted by the State.

ATTACHMENT G

Encounter Data Set Elements

ELEMENTS	TYPE OF RECORD				
	PHYS & OTHER PROVS	HOSP	LTC	DRUGS	DENTAL
Beneficiary/Enrollee ID	X	X	X	X	X
Beneficiary/Enrollee Name	X	X	X	X	X
Beneficiary/Enrollee DOB	X	X	X	X	X
Plan ID	X	X	X	X	X
Physician/Supplier/Provider ID	X	X	X	X	X
Attending/Ordering/Referring Performing Physician ID	X	X	X	X	X
Provider Location Code/Adress	X	X	X	X	X
Place of Service Code	X	X	X	-	X
Specialty Code	X	-	X	-	-
Date(s) of Service	X	X	X	X	X
Units of Service/Quantity	X	X	X	X	X
Principal Diagnosis Code	X	X	-	-	-
Other Diagnosis Code(s)	X	X	-	-	-
Procedure Code	X	X	X	-	-
EPSDT Indicator	X	-	-	-	X
Patient Status Code	-	X	X	-	-
Revenue Code	-	X	X	-	-
National Drug Code	-	-	X	X	-
Dental Quandrant	-	-	-	-	X
Tooth Number	-	-	-	-	X